

**REPORT TO THE 27TH LEGISLATURE
STATE OF HAWAII
2013**

Pursuant to House Concurrent Resolution 32, House Draft 1
Requesting the Governor's Office to Conduct a Study on the Efficacy of
Combining State Government Health Policy, Planning, and Purchasing in
a Single Agency in Order to Advance Transformation of Hawaii's
Healthcare System and Universal Access to Care.

Prepared by
Governor's Office
State of Hawaii
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REPORT TO THE 27TH LEGISLATURE

House Concurrent Resolution 32, House Draft 1

BACKGROUND

In 2012 the Legislature passed House Concurrent Resolution 32, House Draft 1 requesting the Governor's Office to conduct a study on the efficacy of combining state government health policy, planning, and purchasing in a single agency in order to advance transformation of Hawaii's health care system and universal access to care. As noted in the resolution, nearly a quarter of the state's budget is devoted to public health insurance purchases for Medicaid and the Employer Union Health Benefits Trust Fund (EUTF).

HEALTH CARE SYSTEM AND THE AFFORDABLE CARE ACT

The health care system in the United States has evolved to be extremely effective for trauma and life-threatening conditions but very poorly organized to meet the everyday needs of the greatest number of people. Its fee-for-service payment system rewards visits to specialists, high-cost procedures, fragmentation, and in-patient care and, in contrast, fails to support prevention, primary care, systematic organization of services, and population health. Our health care system is a multi-trillion dollar industry that largely resists the use of effective information technology and is generally arranged to be inconvenient and bewildering to its users. Although it is the most expensive health care system in the world, the U.S. system fails to insure 15% of the population – nearly 50 million people – who have few choices for care outside of costly and crowded emergency rooms. Hawaii fares better in this respect because of our Prepaid Health Care Act but still hosts an uninsured population of 80,000 – 100,000 people. Meanwhile, as the growth in our health care system's costs double or triple ordinary inflation and become increasingly unsustainable, the obesity epidemic and its attendant health woes add unprecedented urgency to changing the whole system.

Fortunately, the federal Patient Protection and Affordable Care Act (ACA) presents opportunities to make many of the needed changes to expand coverage and improve cost and quality indicators. Some of the many concepts, recommendations, and mandates from the ACA include:

- Insurance reform to increase transparency, coverage, and investment in medical services.
- Expansion of Medicaid eligibility to all low income individuals without regard to assets.
- Development of health insurance exchanges as markets for consumer- and business-friendly health insurance accompanied by tax credits to defray costs for low- to middle-income individuals.
- Extending to states options to develop a "basic health plan" to reduce possible concerns in the transition from Medicaid eligibility to insurance exchange.
- Rejection of exclusions for pre-existing conditions.
- Eliminating lifetime benefit caps.
- Identifying ten "essential health benefits" that must be offered by insurers.
- Promoting timely access to effective health information and care.
- Reducing health disparities and addressing social determinants of health.
- Promoting patient-centered primary care and improved care management.

- Incentivizing use of evidence-based preventive and clinical care.
- Encouraging integrated health care system development such as “accountable care organizations.”
- Penalizing poor care and inadequate coordination for inpatient services and transitions of care.
- Encouraging home and community-based care and coordination of individuals dually eligible for both Medicaid and Medicare.
- Encouraging state- and community-based innovation to support programs that improve health, document quality, and reduce cost inflation.
- Encouraging new ways of envisioning, training, and deploying the health care workforce.
- Promoting the use of electronic health records, information exchange, and data analysis for care improvement and consumer-friendly transparency.

The expected widespread and transformational effects of the Affordable Care Act are dependent on the work of federal, state, and local governments, private agencies, insurers, and providers of many kinds. Within the Hawaii State government responsibility for health insurance purchase and regulation, health care services, information systems, and health care workforce is spread across at least eight departments, namely, Department of Health (behavioral health and services for the uninsured), Department of Human Services (Medicaid programs), Department of Commerce and Consumer Affairs (Insurance Division and health professions licensing), Department of Labor and Industrial Relations (Hawaii Prepaid Health Care Act and workers compensation coverage), the Department of Human Resources Development (State employees), the Department of Budget & Finance (EUTF), the Attorney General (ensuring regulatory compliance), and the Office for Information Management and Technology (health information technology). Outside of State agencies, nonprofit organizations have been designated to carry out public purposes that also must coordinate with state activities to ensure successful change in our health care system. Two such nonprofit entities are our insurance exchange, the Hawaii Health Connector, and the Hawaii Health Information Exchange.

ADMINISTRATION’S WORK TOWARD HEALTH CARE TRANSFORMATION

The Governor’s interest in health care transformation was manifested in his New Day Plan and put into action in 2011 with the hiring of a Healthcare Transformation Coordinator and Senior Advisor on Health Care. These two created a public-private process to identify priorities for Hawaii to embrace the “triple aim” of improved quality, greater cost-effectiveness, and better population health. Working with a coalition of health reform-minded community stakeholders the agreed-upon priorities were identified as:

- Promoting Patient-Centered Health Care Homes, increasing care coordination, and encouraging health system integration;
- Changing the way health care is paid for to move from a fee-for-service methodology to one that pays for improved outcomes and quality; and
- Expanding the use of electronic health records, health information exchange, and building the capacity to aggregate and analyze health data for continued improvement.

These priorities are expected to address the problems identified above such as fragmentation, misplaced emphasis on specialty care, rewarding processes instead of outcomes, and failure to engage patients and their families in better health. Effective use of health information technology is foundational to transforming the delivery and payment systems.

While the group continues to develop plans to turn these delivery and payment system priorities into reality, the Governor's Office is also coordinating ACA implementation as a key responsibility. In 2012, an ACA Implementation Manager was hired whose work is to ensure that all activities across departments is done in mindful coordination and in accordance with the Governor's vision for a transformed health care system. As noted above, the ACA has broad impact and affects the work of many Departments. In addition, the Governor's and Departmental staffs work closely with federally-funded private agencies designated to perform key ACA-related functions; chiefly, the health insurance exchange (called the Hawaii Health Connector) and the Hawaii Health Information Exchange.

FINDINGS

In response to House Concurrent Resolution 32, House Draft 1 and the Administration's own quest to create the most effective governmental structure to ensure appropriate health system change, the Governor's Office identified two states that combined health policy and health guarantor responsibilities in a single agency and assessed their applicability to Hawaii's needs.

Vermont. The population of the state of Vermont at 625,000 is less than half that of Hawaii. The state is also geographically compact compared to Hawaii's dispersed islands. Their governmental structure is comprised of only six large departments (which are known as "agencies"). Their Agency of Human Services is made up of the Departments of Children and Families, Health, Corrections, Mental Health, Disabilities and Aging, and Health Access. The Department of Health Access, in turn, is responsible for prescription assistance, Medicaid, the insurance exchange, and health quality and cost innovation. For at least twenty years, Vermont has focused on health care access, quality improvement, and health status improvement. As a result, their Department of Health Access includes the Blueprint for Health, which oversees Vermont's efforts in delivery system and payment transformation, health information technology and data reporting, chronic disease management and health improvement, and access to care initiatives. In its efforts to ensure universal coverage, Vermont has created a health authority called the Green Mountain Care Board, which interacts closely with the Department of Health Access and the Blueprint, the legislature, and the administration to address health policy and funding issues. Similar to Hawaii, public services are largely centralized at the state level rather than in county offices.

Oregon. Oregon has a large population (nearly four million) spread out over a sizeable geographic area. The Oregon Health Authority was created by the legislature in 2009 and is still transitioning to its full oversight of public health, behavioral health, Medicaid and medical assistance programs, and teachers and public employee health benefits. The Authority and the Oregon Health Policy Board that oversees it are the products of decades of public discourse and legislative action to comprehensively transform health care in the state. In the late 1980s, Oregon was a pioneer in developing a public health plan that provided evidence-based effective benefits while denying care that was not clinically beneficial or cost-effective. Oregon counties have considerable responsibility for carrying out public policy and expending funds from the state-level Health Authority. Oregon's work in health care transformation has also included stakeholder processes that supported legislative action to standardize administrative procedures and data collection, improve health equity and remove barriers to care, shift the focus to prevention, and report publicly on the performance of the health care system.

The Hawaii State Departments of Health, Human Services, and Commerce and Consumer Affairs, and the Employer Union Health Benefits Trust Fund identified both positive and negative potential in

combining health policy, planning, and purchasing. The most significant positive aspect of combining departments was the consistency possible between public health priorities and purchasing power for publicly-purchased health benefits. It was clear that a single agency could most effectively use the State's purchasing power to ensure that Medicaid, EUTF, and other programs demanded standards for reporting, service delivery, and payment consistent with improved quality, cost-effectiveness, and better population health.

Significant negatives were also identified, including that a combined agency may be more likely to focus on addressing the structure and costs of the medical delivery system at the expense of public health priorities. Other concerns included the possibly arbitrary decision on where to redraw lines of responsibility since health care policy, delivery, workforce, and information are dispersed across many agencies. A department that truly encompassed all aspects of health care would be too large and cumbersome to be effective. Concerns were raised about communicating the benefits of a combined purchasing policy with EUTF beneficiaries who might fear that such an initiative would result in being pooled with higher cost Medicaid enrollees. Finally, one informant noted that the complexities of creating a new department could distract the State from accomplishing the work of transformation in a timely manner.

Implementation of the Affordable Care Act is a priority that affects many different departments and programs and will continue to be so until at least 2014. Working toward a major change in structure and responsibilities across departments would be an added burden for workers who now have significant new responsibilities and timelines. It was noted that the process of addressing cross-departmental ACA implementation has itself improved communications, coordination, and focus on State priorities and these dynamics could carry forward to future initiatives.

RECOMMENDATIONS

1. The transformative concepts promoted by the Affordable Care Act, the experiences of other states that have been leaders in this field, and our own work to identify and advance change in our delivery and payment systems underscore the reality that health care is now a public-private responsibility in ways unimaginable thirty years ago. This changed environment is due in large part to escalating costs that have made health care unaffordable for most individuals while constraining the competitiveness of US businesses and consuming ever-increasing portions of state and federal budgets. In addition, advances in health information technology promise better care, a greater capacity to measure costs and quality, and opportunities to increase consumer engagement and convenience.

In the new world of health care delivery and finance, with significant shared responsibility between the public and private sectors, Hawaii would benefit by establishing a new agency focused on the health care sector. The responsibilities for this new entity should include coordinating activity across private payer, delivery, and information systems and ensuring that health care policy reflects the needs and demands of consumers. This agency might best be affiliated with the Department of Commerce and Consumer Affairs because its work would be primarily related to the external (i.e., non-State provided) delivery system, including insurers, licensed providers, and consumers. We recommend that the legislature consider establishing such an agency pursuant to the results of the study outlined in recommendation 2 below.

2. With new options and mandates in the Affordable Care Act augmenting Hawaii's remarkable Prepaid Health Care Act and existing public insurance programs, we should make a serious assessment of our health care system and design a plan for moving forward. Questions that should be addressed include:
 - What is the best and most sustainable strategy for Hawaii to achieve universal health insurance coverage?
 - How can we align the providers and payment structures to ensure progress toward higher quality care and sustainable costs?
 - How can we ensure that our public health care investment results in better health for all and not merely in competent clinical service?
 - How can state government best fulfill its public purpose to ensure safety, quality, cost-effectiveness, and transparency for consumers while also encouraging and supporting innovation and community-appropriate flexibility in the health care system?

We recommend engaging a consultant to perform an assessment of Hawaii's unique health coverage and delivery systems to help us plan policy, investments, and programs to attain our health and health care system goals. It should be noted that the Vermont legislature commissioned such a study, which became a touchstone for subsequent health policy initiatives in that state.

3. Because of the concerns raised, we do not recommend immediate action toward combining State-controlled health services and purchases such as public health, Medicaid, and EUTF into a single department. However, the study proposed above would provide additional information about the optimal state structure to support public health and health care policy. We recommend further consideration of this concept upon completion of the study. Meanwhile, these programs should work together to develop common standards for clinical and cost measures and requirements for reporting and contractual expectations for clinical delivery and payment models. Clinical and cost data for Medicaid, EUTF, and certain DOH-supported services should be aggregated, analyzed, and used for public health and system improvement purposes.